Testimony before the Insurance and Real Estate Committee
Public Hearing on 3/3/15 - Senate Bill 982

Good afternoon: Senator Crisco, Representative Megna, and members of the Insurance and Real Estate Committee:

My name is Linda Ross, and I live in Norwalk. I am the legislative and media spokesperson for Christian Science in Connecticut. I'm here today to speak in favor of **SB 982, An Act Concerning Health Treatment or Care Provided by Religious Nonmedical Providers under Health Insurance Policies or Health Benefit Plans.** I would like to express appreciation for your consideration of this legislation, which allows health plans that choose to cover religious nonmedical health care services to do so in a way that provides appropriate safeguards for coverage determinations and claims payment and is consistent with the nonmedical nature of these services.

The genesis for this language is a recommendation contained in the final report to the Connecticut General Assembly of the SustiNet Health Partnership Board of Directors in January 2011. That recommendation, a copy of which is attached as **Exhibit A**, counseled the development of appropriate quality assurance criteria for nonmedical providers.

A key aspect of the proposed language of this bill is that **it does not require any health insurance policy or health benefit plan to provide coverage for the services of religious nonmedical providers.** It merely ensures that plans that provide such coverage may do so in a way that does not hinder patient access to care. The application of medical standards and criteria to religious nonmedical services can restrict access to care. Individuals may be seeking help for a health problem for which they do not have a medical diagnosis, and they may not want medical involvement to be a prerequisite to getting care. This bill ensures access to appropriate services that are consistent with a patient's decision to turn to religious nonmedical means for health needs.

The proposed language leaves the choice of what services should be covered and the particular safeguards to be applied up to the health plan deciding to offer the benefit. A plan may decide, for example, to apply particular provider credentialing requirements, to cover certain specific services, to impose a cap on benefits, or to require claims to be reviewed for appropriate utilization by nonmedical personnel.

The concept of relieving health plans of having to apply medical criteria to religious nonmedical services is not new. The language of this bill is, in fact, strikingly similar to the language of existing statutory provisions in Massachusetts and several other States (see **Exhibit B**). The federal Medicare law contains a provision requiring religious nonmedical health care institutions to demonstrate compliance with nonmedical eligibility and claims review criteria (see **Exhibit C**). Here in Connecticut, Conn. Gen. Stat. Ann. §§ 39a-494 and 38a-521 provide that individual and group health plans may, at their discretion, cover home health services provided pursuant to a nonmedical system of health care (see **Exhibit D**).

I hope that this language will make it clear to health insurers that they may offer plans that cover religious nonmedical health care services in this State. I believe that such a result would inure to the benefit of Connecticut residents who, like myself, have found these services to be reliable and effective. I have been a practicing Christian Scientist throughout my adult life. I first became aware of the connection between spirituality and my health when, as a pre-med student, I had a medically verified healing of injuries I sustained during an automobile accident.

Christian Science services are an example of the type of care that could be covered by health plans pursuant to the language of this bill. Although Christian Science services have been covered in health insurance plans since the beginning of the last century, the institution of medically based managed care mechanisms has made this coverage much less prevalent in recent years.

More and more people today are becoming aware of the positive role that spirituality can play regarding their health. Good health care should be about finding solutions that keep people healthy and promote well-being. Connecticut continues to innovate in finding solutions that provide improved access to better care. I believe that spiritual care services can play a vital role in that process.

Thank you for your consideration of this legislation.

Report to the Connecticut General Assembly

From the SustiNet Health Partnership Board of Directors

JANUARY 2011

SustiNet Health Partnership

Acknowledgements

This report reflects the work of many dedicated individuals, agencies and organizations across the state and beyond. We'd like to acknowledge the work of the Board members:

Nancy Wyman (Co-Chair) • Kevin Lembo (Co-Chair)
Bruce Gould • Paul Grady • Bonita Grubbs • Norma Gyle • Jeffrey Kramer
Estela Lopez • Sal Luciano • Joseph McDonagh • Jamie Mooney*

And members of the five advisory committees and three task forces:

Health Disparities and Equity Advisory Committee
Health Information Technology Advisory Committee
Patient Centered Medical Home Advisory Committee
Preventive Healthcare Advisory Committee
Healthcare Quality and Provider Advisory Committee
Healthcare Work Force Task Force
Tobacco and Smoking Cessation Task Force
Childhood and Adult Obesity Task Force

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And a final note of thanks to the staff of the Office of the State Comptroller and the Office of the Healthcare Advocate who provided continuous support to the Board and its committees and task forces.

This report is hereby submitted to the Connecticut General Assembly on January 7, 2011:

Nancy Wyman, Lt. Governor

Kevin Lembo, State Comptroller

* Jamie Mooney recently resigned her Board post; we thank her for her contributions.

REPORT OF THE QUALITY AND PROVIDER ADVISORY COMMITTEE TO THE SUSTINET BOARD OF DIRECTORS

I. Executive Summary

The Healthcare Quality and Provider Advisory Committee (HQPAC) was established to advise the SustiNet board of directors on matters related to health care quality, safety, cost and provider payment. The committee, through a collaborative process, has developed recommendations in each of these areas. The committee believes that SustiNet offers the opportunity to provide high-quality, safe health care to its covered population through an efficient and effective model of care delivery. The SustiNet board should take care to incorporate the following elements in the SustiNet design:

- Use of evidence-based standards of care;
- Use of recognized quality metrics for quality measurement and provider feedback;
- Effective cost control through a combination of payment design and delivery system redesign that promote provider accountability for costs and reduce unnecessary care;
- Ongoing oversight of and advisement on quality, safety and payment by standing committees;
- Support for providers through health information technology, implementation of the medical home model and payment for better, more efficient care management.

II. Purpose and mission of this Committee

Public Act No. 09-148: AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN, directed the Healthcare Quality and Provider Advisory Committee (HQPAC) to advise the SustiNet board of directors on four issues related to the design of SustiNet:

- Procedures that require or encourage providers to engage in reviews of their quality of care and to develop plans for quality improvement;
- Adoption of clinical care and safety guidelines;
- Hospital safety standards; and
- Quality and safety recommendations that will help slow the growth of per capita health care spending.

In addition, the SustiNet board asked the committee to recommend a payment approach through which SustiNet would pay health care providers.

III. Members

The members of the Healthcare Quality and Provider Advisory Committee are:

Margaret Flinter (co-chair)	Vice President and Clinical Director

VII. Recommendations

The committee also developed specific recommendations for each of our areas of focus, and those are listed below.

Recommendations related to quality assessment and improvement and clinical care and safety guidelines

1. Create two standing Clinical Standards Committees – one to advise SustiNet on quality and payment and one to advise on safety. The responsibilities of the committees will intersect, and there should be regular communication between the committees on common areas of responsibility and mutual concern. These committees should be representative of all participating provider groups, to conduct ongoing reviews of best practices and establishment/adjustment of disease-specific, evidence-based clinical guidelines and should promote education and sharing of best practices. The committees also should reflect the diversity in Connecticut's population, in terms of race and ethnicity.
2. Identified guidelines will become the basis for quality measures. In identifying guidelines, the committees will embrace the goals of efficient and safe care. The committees should focus first on areas of clinical care that offer the greatest potential for cost savings and for individual and population health.
3. SustiNet should use evidence-based practice standards that have already been promulgated and nationally endorsed quality measures that have been appropriately vetted.
4. Communication with all appropriate specialties and sub-specialties will be critical to identifying guidelines that are acceptable to all providers.
5. The patient-centered medical home model should be used to coordinate care. The medical home model should fully embrace the skills and resources of all participating providers as detailed in CT state statutes.
6. Quality measurement should be based on the best available data, whether claims data, electronic medical record (EMR) data, or point-of-service measurements.
7. Quality measures and clinical guidelines should be integrated with EMRs so as to be automatic.
8. These recommendations should be integrated into the design of SustiNet's health information technology early in the design process.
9. Quality measurement should capture inpatient, outpatient, long-term, home care and hospice care.
10. A central database will need to be maintained for population-, patient- and provider-level quality data.
11. Payment-for-measurement might be used as a first step with providers (as with PQRI in Medicare).
12. Quality measures should be disseminated to the public, to providers, and to SustiNet
    a. Which measures should be available to which parties, and at what level of reporting, will need to be established

b. Composite measures that summarize quality measures may be more useful for public reporting and to help patients evaluate care
c. More detailed reporting will be needed for the purpose of quality improvement by providers

13. Educational resources should be available to support physicians and other providers in the areas of quality and safety, particularly to support adoption and diffusion of innovations that promote patient safety.
14. Quality measurement for nonmedical and alternative services should be as stringent as that used for medical services but also consistent with the patient's desire to utilize a nonmedical form of treatment, and also should be based on nationally-recognized standards and measures, if available.
15. Evaluation and reporting of quality measures must take into account the demographics of the patient population served by each provider.
16. SustiNet should develop a central resource for all providers that will:
    a. Provide access to practice management opportunities and clinical programs for practice efficiencies and HIE options
    b. Provide patient educational resources for provider use and patient web access
    c. Promote the proper use of HIE to ensure real-time access to patient data by providers with the goal of providing safe and efficient care

Recommendations regarding safety

The original charge to this committee was to address standards for hospital safety. However, the committee's discussion ranged well beyond hospital safety, and we agreed that SustiNet should be concerned with safety in all care settings.

1. Separate standing quality and safety committees should be established as on-going elements of SustiNet. The responsibilities of the committees will intersect, and there should be regular communication between the committees on common areas of responsibility and mutual concern. Each of these must include consumer representatives and be focused on changing the culture of care as well as the specifics of quality and safety.
2. SustiNet should use existing safety guidelines and safety measures already being reported by hospitals and other providers wherever possible to avoid duplicate efforts.
3. Safety measures should be prioritized to the areas of maximum vulnerability, such as medication errors and system failures in the transitions of care
4. Patient advocates should be represented in all care settings.
5. Institutional safety data (including adverse events) should be transparent and made public.
6. Safety data for individual providers should be collected by SustiNet and provided confidentially to providers.
7. Providers should have access to interpreters for non-English speaking patients at all times, either telephonic or in person.

Exhibit B

Examples of State Statutes That Accommodate Coverage of Spiritual Care Services from Medical Criteria

Massachusetts Massachusetts General Laws Annotated
Part I. Administration of the Government (Ch. 1-182)
Title XXII. Corporations (Ch. 155-182)
Chapter 176O. Health Insurance Consumer Protections
§ 11. Rights of health benefit plans to include as providers religious non-medical providers.

Nothing in this chapter shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers, require such health benefit plans to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers, use medical professionals or criteria to decide insured access to religious non-medical providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by religious non-medical providers, compel an insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious non-medical provider, or require such health benefit plans to exclude religious non-medical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious non-medical treatment or nursing care provided by the provider.
Mass. Gen. Laws Ann. 176O, § 11

Massachusetts General Laws Annotated
Part I. Administration of the Government (Ch. 1-182)
Title XXII. Corporations (Ch. 155-182)
Chapter 176O. Health Insurance Consumer Protections
§ 1. Definitions

As used in this chapter, the following words shall have the following meanings:-- . . ."Religious non-medical provider", a provider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.
Mass. Gen. Laws Ann. 176O, § 1

<u>Other Examples</u>
Maine
- Me. Rev. Stat. Ann., tit. 24-A, § 4307
- Me. Rev. Stat. Ann., tit. 24-A, § 4301-A(17)

Alaska
- Alaska Stat. § 21.07.080
- Alaska Stat. § 21.07.250(17)

Washington
- Wash. Rev. Code Ann. § 48.43.520
- Wash. Rev. Code Ann. 48.43.540

Exhibit C

Excerpt from the Medicare Act Regarding Accommodation of Religious Nonmedical Health Care Institutions from the Application of Medical Criteria

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security
Subchapter XVIII. Health Insurance for Aged and Disabled
Part E. Miscellaneous Provisions
§ 1395x. Definitions

(ss) Religious nonmedical health care institution
(1)The term "religious nonmedical health care institution" means an institution that--
(A). . . (I) provides the Secretary with such information as the Secretary may require to implement section 1395i-5 of this title [pertaining to conditions for coverage of religious nonmedical health care institution services], including information relating to quality of care and coverage determinations; . . .

(3)(A)(i) In administering this subsection and section 1395i-5 of this title, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1395i-5(a)(2) of this title the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A of this subchapter for services provided in such an institution.

(B)(i) In administering this subsection and section 1395i-5 of this title, the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or such personnel.

(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A of this subchapter, are excessive, or are fraudulent.

Exhibit D

Examples of Connecticut Insurance Statutes That Provide Accommodation from Medical Criteria

Connecticut General Statutes Annotated
Title 38A. Insurance
Chapter 700C. Health Insurance
Part II. Individual Health Insurance
§ 38a-494. Home health care by recognized nonmedical systems

Notwithstanding the provisions of section 38a-493, no insurer, health care center or issuer of any service plan contract for hospital or medical expense delivered, issued for delivery or renewed in this state shall be prohibited from providing, at its own discretion, coverage for home health care to persons employing a recognized nonmedical system of health care and treatment.

Connecticut General Statutes Annotated
Title 38A. Insurance
Chapter 700C. Health Insurance
Part III. Group Health Insurance
§ 38a-521. Home health care by recognized nonmedical systems

Notwithstanding the provisions of section 38a-520, no insurer, health care center or issuer of any service plan contract for hospital or medical expense delivered, issued for delivery or renewed in this state shall be prohibited from providing, at its own discretion, coverage for home health care to persons employing a recognized nonmedical system of health care and treatment.